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ABSTRACT

Although several theoretical positions deal with the concept of childhood depression, accurate measurement of depression can only occur if valid and reliable measures are available. Current efforts emphasize direct questioning of the child and quantification of parents' observations. One scale used to study childhood depression, the Personality Inventory for Children (PIC), correlates with many of the characteristics associated with childhood depression. A cluster analysis of 1,800 PIC profiles has revealed 11 replicated patterns or profile types. The PIC Depression scale enters into the identification of three of these types. The first, Type 3 Profile, suggests a child or adolescent with chronic cognitive deficits and academic failure who has difficulty adjusting to change. For these children the Depression scale reflects the effect of social incompetence. The Type 7 Profile represents a combination of depression and externalization symptomatology. These children are often angry or insecure, have poor relations with their parents, and often come from disrupted, chaotic families. Type 9 Profile children are likely to be referred for help due to an observed disturbance of mood and/or somatic complaints. These children feel competitive or angry with siblings and depend on parents who are often viewed as clinically depressed and in need of individual treatment. (Tables summarizing the criteria for depression, and the PIC factor structure, psychometric characteristics, and profile types are appended.) (NRB)

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Empirical Evidence for Childhood Depression

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The growing interest in the clinical and school-based study and treatment of childhood depression (cf. Seagull & Weinshank, 1984) requires a precise definition of this concept. The current literature documents results that derive from a lack of clearly detailed criteria that, if available, would provide effective communication between investigators as well as allow practitioners to draw some initial conclusions that could then be applied in their work with children.

What is depression? Is it a commonly occuring dysphoric mood measured by self-report and the observations of parents or teachers, or is it a symptom that signifies maladjustment and the inability to achieve necessary life tasks? To move beyond "depression" as a characteristic, i.e., "he is depressed about leaving his school," or "he has been sullen and depressed for weeks," one must establish that depression represents an expected pattern of characteristics in the same manner as when this label

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is applied in the study and classification of adults. Does depression constitute a syndrome in which mood, motivation, physiological state, and cognitive activity covary in a specified manner?

Does this syndrome occur in relative isolation, or does it occur frequently with other problem behavior constellations? Does the depression syndrome occur before the appearance of other behavior problems (i.e., is it "primary")?, or does it develop after the appearance of other behavior problems (i.e., is it "secondary")? Will the more thorough study of the syndrome of depression lead to the documentation of a depressive disorder, in which the clinical picture, its development or course over time, response to treatment, and specific family/environmental/and biological-genetic correlates are characteristic?

It is an unfortunate reality that much of the description and classification enterprise for childhood disorders has been dominated until quite recently by theoretical concerns and assumptions. Our observations of child behavior have been made through theoretical "filters" that assign meaning to these observations. It is necessary to review briefly the various current theoretical positions that deal with the concept of childhood depression:

1. One theoretical position concludes that neither depressive syndrome nor disorder can exist in childhood as a child's superego is insufficiently developed. The characteristics said to define childhood depression are often seen in adjusted children and furthermore vary in incidence with stage of development. This position has been associated

with psychoanalytic theory. Proponents of psychoanalytic theory have also traditionally demonstrated a bias against the classification and quantification of child behavior (i.e., "all children are unique"), as well as support for indirect methods of child assessment, such as the use of playroom observation and projective techniques.

2. A second position has had an equally negative impact on the study of childhood depression. It posits that the essential clinical features of depression are not present in childhood, but that depression underlies such diverse behaviors as conduct disorders, hyperactivity, enuresis, learning disabilities, and somatic complaints, which serve as "behavioral equivalents" of depression that is thereby "masked." This perspective that proposes an ubiquitous but nevertheless unobservable phenomenon excludes depression from legitimate study.

3. A third position states that the depressive syndrome occurs in childhood, but includes certain unique characteristics and symptoms that vary with developmental level, such as separation anxiety during the elementary grade years and negative acting out behaviors and school difficulties for male adolescents. In this position a clearly observable depressive syndrome may be accompanied by a diverse array of conditions, such as separation anxiety, anorexia nervosa, conduct disorders, hyperactivity, and school failure.

4. A fourth position is that clinical depression in childhood is quite similar to that found in adults and has been an underdiagnosed condition.

The clear advantage of these last two perspectives is that they are amenable to direct systematic study. In fact, the data in support of these positions have come from direct questioning of children, parents, and other observers of child behavior such as teachers.

The prevalence of depression in the normal population has been estimated at from less than one fifth of one percent (Rutter, Tizard, & Whitmore, 1970), to as high as 50% (Albert & Beck, 1975). Considering the lack of consensus and shared definition, it is not surprising that the incidence in referred samples also varies widely from less than one percent (Poznanski & Zrull, 1970), to well over 50% (Brumback, Jackoway, & Weinberg, 1980). Cantwell and Carlson (1982) have documented the effect of this lack of correspondence among contemporary diagnostic criteria by applying both the highly detailed DSM-III and Weinberg criteria to a sample of 102 child and adolescent psychiatric patients. Twenty-seven percent met DSM-III criteria and 37% met Weinberg criteria, although over 40% of the children meeting Weinberg criteria did not meet DSM-III criteria. These results are easily understood when these two sets of criteria are compared. The Weinberg criteria include a good deal of

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Table 1 About Here

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noncompliant, school-related, and somatic characteristics not found in DSM-III.

Accurate measurement of depression as a symptom and syndrome can only occur if valid and reliable measures are available.

Only then can the results of various studies be accurately compared, only then can symptom course, response to treatment, and biological, familial, and environmental correlates be studied. Current efforts in this area emphasize direct questioning of the child as well as quantification of parent's observations.

I would like to briefly outline some of the preliminary results of our efforts that have used the Personality Inventory for Children (PIC) (Lachar, 1982; Lachar & Gdowski, 1979; Wirt, Lachar, Klinedinst, & Seat, 1984) in the study of childhood depression. By way of introduction, the factor structure of the 46-item rationally constructed PIC Depression scale is presented as well as inventory items that correlate substantially with scale total raw score.

Table 2 About Here

Scale items were selected through the consensus of professionals because "depression" was not an acceptable diagnosis during the mid-to-late 1960's, and therefore it was not possible to collect a criterion group of depressed children which would have allowed the option of empirical construction of a depression scale. Currently available information suggests that this scale correlates with many of the characteristics associated with childhood depression. (See also Leon, Kendall, and Garber [1980] and Lobovits and Handal [in press].)

Table 3 About Here

A recent survey of over 1300 profiles collected by an urban midwest child psychiatry service revealed that the Depression scale obtained an elevation in the clinically interpretable range (>69T; Lachar & Gdowski, 1979) for approximately half of children aged 8 through 15. Depression is therefore a likely symptom for half of the children seen in urban inner-city child psychiatry clinics (at least within those that exclude children who are believed to be retarded or learning disabled without accompanying behavioral or emotional problems). However, this observation sheds no light on the presence and incidence of childhood depression as a syndrome or disorder.

Not disuaded by observations that the identification of childhood disorders has never come from direct data analysis, I and three colleagues have spent the last four years in the cluster analysis of 1800 PIC profiles. The twelve substantive clinical scales were entered for each profile: Achievement (ACH), Intellectual Screening (IS), Development (DVL), Somatic Concern (SOM), Depression (D), Family Relations (FAM), Delinquency (DLQ), Withdrawal (WDL), Anxiety (ANX), Psychosis (PSY), Hyperactivity (HPR), and Social Skills (SSK).

This search for repeated profile patterns or types has identified 11 replicated patterns or profile types that can be identified through application of a reasonably short set of sequentially applied rules (Lachar, Kline, & Boersma, in press).

Figure 1 About Here

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Although approximately half of the individual profiles have an elevated Depression scale, this scale enters into the identification of only three of 11 profile types.

In the first of these three profile types, Depression is one of three possible secondary scales, the two others being Withdrawal and Social Skills. External correlates of this Type 3 Profile suggest a child or adolescent with chronic cognitive deficits and academic failure. These children especially have difficulty in adjusting to change. Here the Depression scale reflects the effect of social incompetence.

In two profile types the Depression scale is a required elevation. Each profile type classifies approximately 6% of clinic evaluations. The Type 7 Profile represents a combination of depression and externalization symptomatology. These children have poor relations with their parents and the families are often broken or chaotic. Anger and feelings of insecurity are also characteristic. Children who obtain a Type 9 Profile are more likely to be referred due to an observed disturbance of mood and/or somatic complaints; when problems are school-related they occur at a significantly older age than those school problems found for children who do not obtain a Type 9 profile, and these school problems are not found to be related to cognitive deficits, retardation, or failure to demonstrate grade-appropriate achievement. These children feel competitive and/or angry with siblings and depend on parents who are often viewed as clinically depressed and in need of individual treatment.

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Table 1. DSM-III AND WEINBERG CRITERIA FOR DEPRESSION

Weinberg	DSM-III
Both	**Either**
1. Dysphoric Mood	1. Dysphoric mood (appearance)
a. statements/appearance: sadness, loneliness, unhappiness, hopelessness, and/or pessimism	2. Loss of interest/pleasure in activities
b. mood swings, moodiness	**Four or more of these eight:**
*c. irritable, easily annoyed	
d. hypersensitive/cries easily	
*e. negative/difficult to please	
2. Self-Depreciatory Ideation	6. Feelings of worthlessness, self-reproach, or excessive/inappropriate guilt
a. feeling worthless, useless, dumb, stupid, ugly, guilty	
b. belief of persecution	
c. death wishes	
*d. desire to run away/leave home	
e. suicidal thoughts	8. Recurrent thoughts of death, suicidal ideation or attempt
f. suicidal attempts	
*Two or more of these eight:	
*3. Aggressive Behavior/Agitation	3. Psychomotor agitation/retardation (hypoactivity) [?]
a. difficult to get along with	
b. quarrelsome	
c. disrespectful of authority	
d. belligerent, hostile, agitated	
e. excessive fighting or sudden anger	
4. Sleep Disturbance	2. Insomnia or hypersomnia
a. initial insomnia	
b. restless sleep	
c. terminal insomnia	
*d. difficulty waking in morning	
5. Change in School Performance	7. Diminished ability to think or concentrate
a. frequent teacher complaint: daydreaming, poor concentration, poor memory	
*b. loss of usual interest in non-academic activities	
6. Diminished Socialization	4. Loss of interest/pleasure in activities (apathy) [?]
a. decreased group participation	
b. less friendly/outgoing	
c. socially withdrawing	
d. loss of usual social interests	
*7. Change in Attitude Toward School	
a. does not enjoy school activities	
b. desires to avoid/refuses school	

DSM-III and Weinberg Criteria for Depression (continued)

Weinberg	DSM-III
*8. Somatic Complaints a. non-migraine headaches b. abdominal pain c. muscle aches/pains d. other	
9. Loss of Usual Energy a. loss on non-school activities b. decreased energy/mental and/or physical fatigue	5. Loss of energy/fatigue
10. Unusual Change in Appetite/Weight	1. Poor appetite/significant weight loss; increased appetite/ significant weight gain (no expected weight gain)
Duration At least one month Represents a change in behavior	**Duration** At least two weeks

( ) = <6 years of age
Adapted from Cantwell (1983)

Table 2

The PIC Depression Scale: Factor Structure & Items
with Substantial (>.39) Correlation to Total Raw Score

I.	Brooding, Moodiness	
	My child often complains that others don't under stand him (her)	
	My child broods some.	
	My child seems unhappy about our home life.	
	Others often remark how moody my child is.	
II.	Social Isolation	
	My child often plays with a group of children.	
	I often wonder if my child is lonely.	
III.	Crying Spells	
	My child often has crying spells	
IV.	Lack of Energy	
V.	Pessimism, Anhedonia	
	My child is as happy as ever.	
	My child is usually in good spirits.	
	My child is almost always smiling.	
	My child usually looks at the bright side of things.	
	Usually my child takes things in stride.	
VI.	Concern with Death and Separation	
	My child worries about things that usually only adults worry about.	
VII.	Serious Attitude	
	My child hardly ever smiles	
VIII.	Sensitivity to Criticism	
	My child tends to pity him (her) self.	
	Little things upset my child.	
IX.	Indecisiveness, poor self-concept	
	My child has little self-confidence	
	My child will worry a lot before starting something new.	
	My child has trouble making decisions.	
X.	Uncommunicativeness	

Table 3

Psychometric Characteristics of PIC Depression Scale

Reliability

Test - retest: .80 - .94
Coefficient alpha: .86

Validity

Construct

r = .33 with Childhood Depression Inventory
r = .61 with CBC Depressed
equivalent to CDI in DSM-III classification:
11 depressed, M = 85.4 T; 39 not DSM-III depressed,
M = 61.2 T

Correlate (Lachar & Gdowski, 1979)

> 79 T : Doesn't eat right
Refuses to go to bed
Hurts self on purpose
Lonely, unhappy
Overly self- critical
Somatic response to stress
Expresses suicidal thoughts
Worries a great deal
Decreased appetite

> 69 T : Frequent crying
Is sad or unhappy much of the time
Mood changes quickly without reason

Table 4

PIC Profile Types that Include the Depression Scale

Type 3: PSY > 79 T & 2: D, WDL, SSK > 69 T

(n=156) Academic and learning difficulties
Developmental delays and cognitive deficits
Problematic peer relations: isolation, withdrawal
20% exhibit severe symptoms

(n=45) WISC-R: VIQ = 71, PIQ = 75, FSIQ = 71
PPVT = 81; PIAT: Math = 80, Reading Rec = 80

Type 7: DLQ > 79 T, D > 69 T, & 2:SSK, WDL > 69 T; PSY > 79 T
(n=173) Externalization: rule violations, impulsivity, aggression, fighting with peers, stealing, temper tantrums, dislike of school
Internalization (parents): labile mood, sadness, sleep difficulties, few friends
Suicide attempts or thoughts
Unhappy at school, yet achieves
Parents display poor child management skills

(n=52) WISC-R: VIQ = 89, PIQ = 94, FISQ = 91
PPVT = 92; PIAT: Math = 92, Reading Rec = 91

Type 9: D > 69 T, ANX > 69 T
(n=161) Correlates across all sources suggest depression, fearfulness, and anxiety:
Sad or unhappy much of the time / frequent crying / worried / somatic complaints / sleep difficulties / emotional lability / nervousness
Suicide attempts, thoughts, & self-injurious behavior
Teachers note crying, listlessness, & somatic response to stress
Less descriptive:
Developmental delays / conduct problems / classroom disturbance / grade failure / retarded achievement

(n=39) WISC-R: VIQ = 97, PIQ = 99, FSIQ = 98 PPVT = 103;
PIAT: Math = 99, Reading Rec = 97

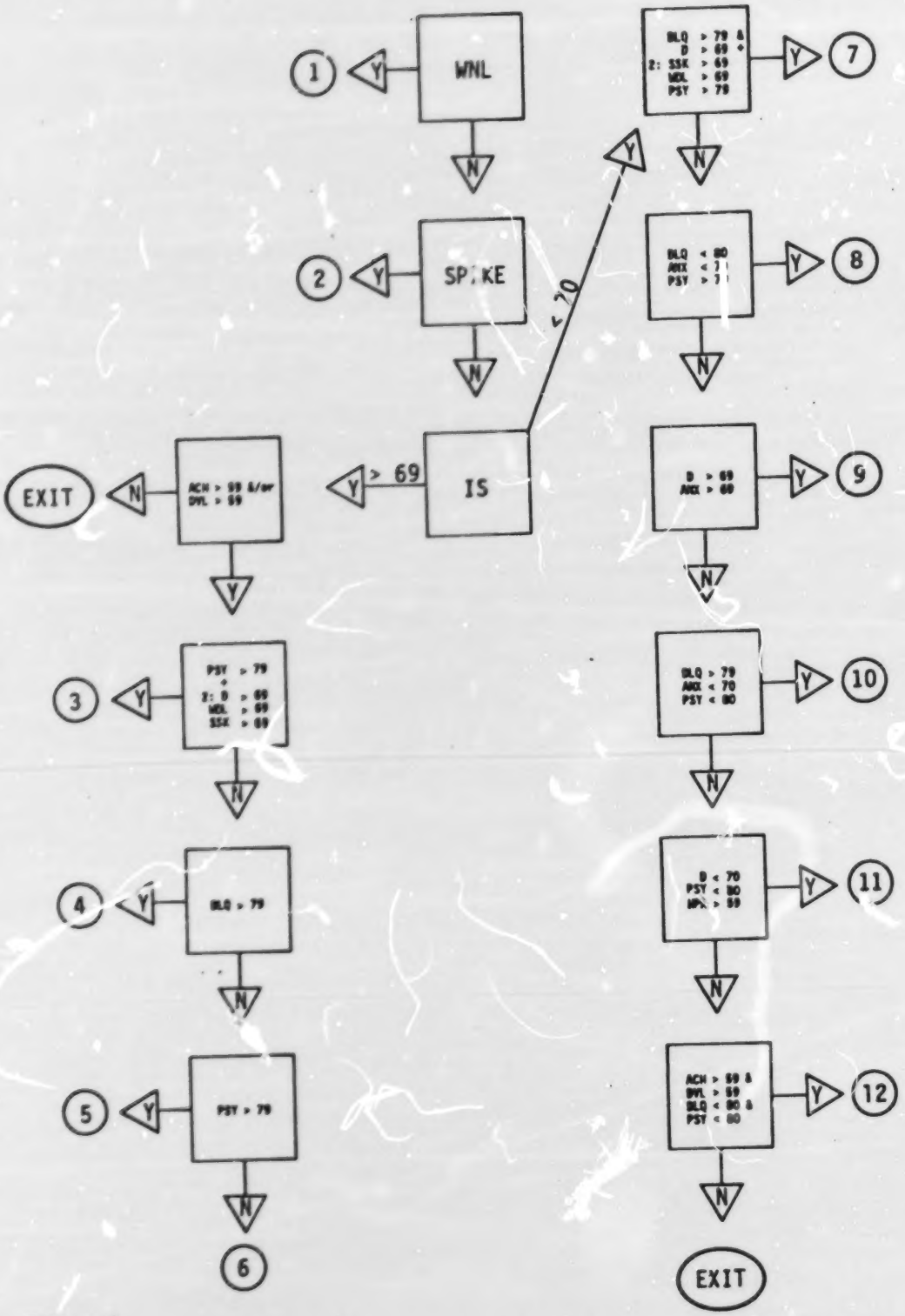

Figure 1
PIC Profile Type
Classification Rules

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